CENTERS FOR MEDICARE & MEDICAID SERVICES

Comprehensive Error Rate Testing (CERT)

Improper Payment Measurement in the Medicare Fee-for-Service Program

www.cms.gov/CERT

Improper Payments Elimination and Recovery Improvement Act (IPERIA) of 2012

- Amended the Improper Payments Information Act of 2002 (IPIA)

- Requires the heads of Federal agencies, including the Department of Health and Human Services (HHS), to annually review programs it administers to improve agency efforts to reduce and recover improper payments

Requirements of IPERIA

- Identify programs that may be susceptible to significant improper payments
- Estimate the amount of improper payments in those programs
- Submit the estimates to Congress
- Report publicly the estimate and actions the Agency is taking to reduce improper payments

Improper Payment

- Payments that should not have been made or payments made in an incorrect amount (including overpayments & underpayments)
  - Payment to an ineligible recipient
  - Payment for an ineligible service
  - Any duplicate payment
  - Payment for services not received
  - Payment for an incorrect amount

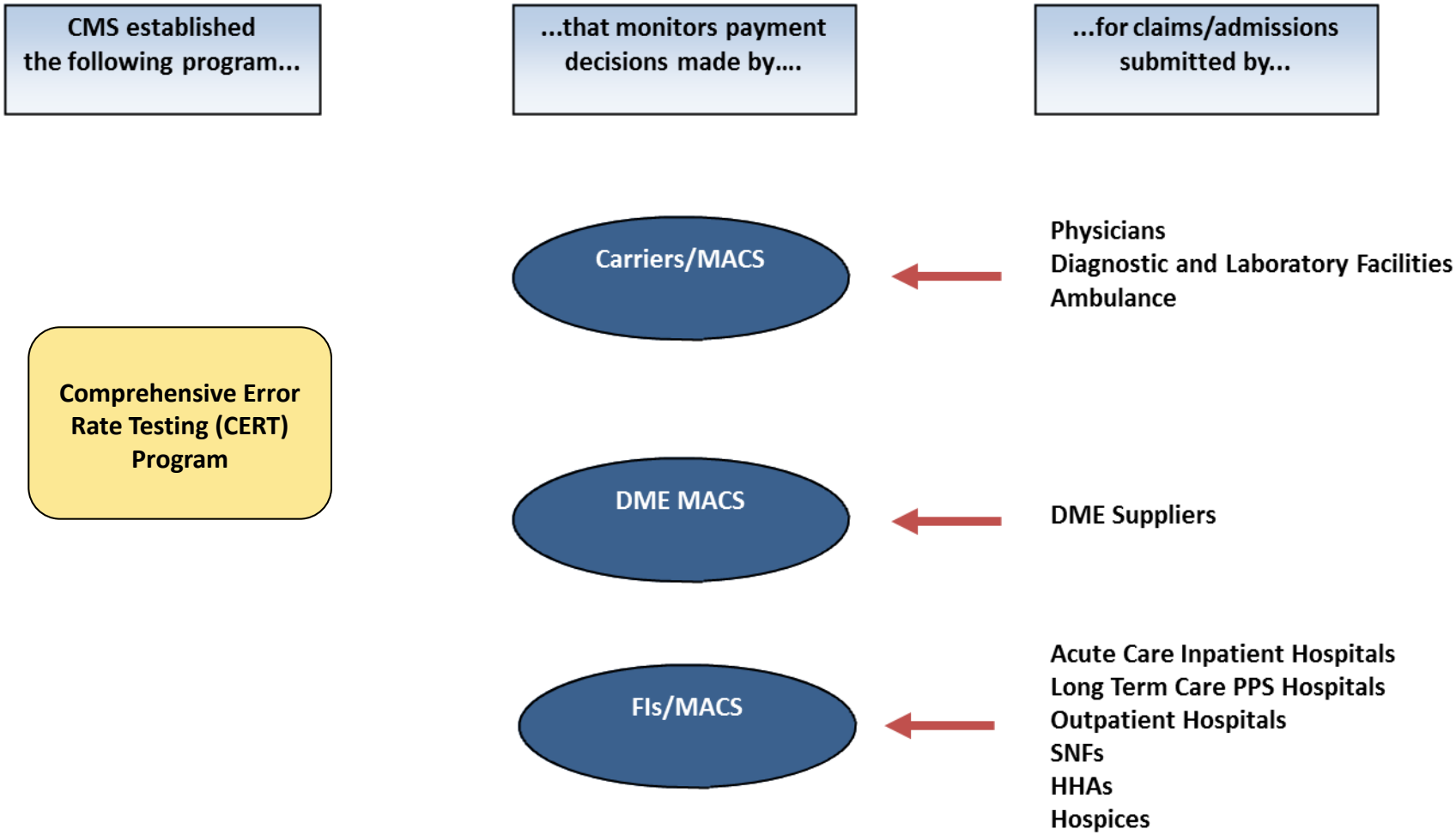
Improper Payment Measurement History

- Office of Inspector General (OIG) Error Rate Measurement
  - 1996-2002:
    - OIG drew a sample of 6,000 claims
    - OIG asked the Durable Medical Equipment Regional Carriers (DMERC), Carriers, Fiscal Intermediaries (FI), and Quality Improvement Organizations (QIO) to review the claims against all coverage, coding, and payment rules
- OIG calculated a single National Claims Payment Error Rate

Improper Payment Measurement History

- Centers for Medicare & Medicaid Services
  - Took over improper payment measurement
    - Transition began in 2001
    - First reported an improper payment rate in November of 2003
  - Current sample size is 50,000 claims
  - Multiple improper payment rates computed:
    - Nationally
    - By Contractor
    - By Service
    - By Provider Type

The CERT Program



The CERT Process

- Claim Selection
- Medical Record Requests
- Review of Claims
- Assignment of Improper Payment Categories
- Calculation of the Improper Payment Rate

CERT Claim Selection

- A stratified random sample is taken by claim type:
  - Part A (excluding acute inpatient hospital services)
  - Part A (acute inpatient hospital services only),
  - Part B
  - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)
- Claims are selected on a semi-monthly basis
- The final CERT sample is comprised of claims that were either paid or denied by the MACs

CERT Medical Record Requests

- The CERT Documentation contractor requests medical records from the provider or supplier that submitted the claim
  - For some claim types (e.g., DMEPOS, clinical diagnostic laboratory services), additional documentation requests are also made to the referring provider who ordered the item or service

- If no documentation is received within 75 days of the initial request, the claim is classified as a "no documentation" claim and counted as an error

- If documentation is received after 75 days of the initial request (late documentation), CERT will still review the claim

CERT Review of Claims

- Upon receipt of medical records, medical review professionals at the CERT Review Contractor conduct a review of the claim and submitted documentation to determine whether the claim was paid properly
  - Nurses, medical doctors, and certified coders review the claims
- Determinations are made regarding whether the claim was paid properly under Medicare coverage, coding, and billing rules
- Improper payment categories are assigned

Assignment of Improper Payment Categories

- Improper Payment Categories
  - No Documentation
  - Insufficient Documentation
  - Medical Necessity
  - Incorrect Coding
  - Other

Calculation of the Improper Payment Rate

- The improper payment amount for each MAC is weighted by its proportion of national total allowed charges
  - This weighting assures that each contractor's contribution to the overall improper payment rate is proportional to the percent of expenditures for which they were responsible during that report period

- After this weighting is complete, the Medicare FFS improper payment rate is calculated
  - The findings are projected to the total Medicare FFS claims submitted during the report period
  - Determinations of overall financial impact are made based upon Medicare FFS expenditures

- Improper payment rates are reported
  - www.cms.gov/cert
  - HHS and CMS Annual Financial Report
  - www.paymentaccuracy.gov

Corrective Actions

- CMS and Contractors analyze improper payment rate data and develop Error Rate Reduction Plans to reduce improper payments

- Corrective actions include:
  - Refining improper payment rate measurement processes
  - Improving system edits
  - Updating coverage policies and manuals
  - Conducting provider education efforts

Corrective Actions: Increased Presence

- Increase Recovery Audit post-payment review, particularly on inpatient hospital claims
- Allocate additional funds to Contractor Medical Director representation at Administrative Law Judge (ALJ) hearings
- Allocate additional funds to the Medicare Administrative Contractors (MACs) to increase their prepayment review on error-prone claim types

Corrective Actions: Education

- Issue Comparative Billing Reports to specified provider peer groups based on various topics
- Issue Quarterly Provider Compliance Newsletters to providers
- Issue Program for Evaluating Payment Patterns Electronic Report (PEPPERs) to inpatient hospitals
- Develop educational guides to improve compliance with documentation requirements

Corrective Actions: Education

- Use the DME workgroup
  - The taskforce consists of Medicare contractor staff who meet regularly to address unique challenges surrounding DME and develop educational material
- Use the A/B Taskforce
  - The taskforce consists of Medicare contractor staff who meet regularly to address unique challenges surrounding Part A and Part B and develop educational materials
- Work collaboratively with coding experts and industry representatives to ensure they understand coding errors/vulnerabilities

Corrective Actions: Improved Collaboration

- Formation of a CERT Technical Advisory Group (TAG) to facilitate communication between the Medicare contractors on matters arising from the administration of the CERT program

- Formation of an A/B and DME Contractor Collaboration Group, the purposes of which are to:
  (1) Allow discussion regarding the CERT medical review process,
  (2) Promote transparency between review entities, and
  (3) Foster understanding between the CERT review contractor and the Medicare contractors

Thank You